National Centre for
Classification in Health (NCCH)

CODING TIPS

1996 Australian Version of ICD-9-CM
Second Edition

Excerpts from Coding Matters (the NCCH Newsletter)

and Official National Coding Centre Guidelines 1994 and 1995.

Australian Coding Standards have been included where necessary.

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Acute HIV infection syndrome (ACS 0102)

The Infectious & Immunology CCCG has recommended the introduction of a coding method which can identify cases of acute HIV infection syndrome. After consultation with coders and clinicians, the following information is provided:

A significant proportion (40-60%) of patients will develop an acute illness shortly after acquiring HIV infection. This illness most commonly presents as a glandular fever like illness with fever, sore throat, lymphadenopathy, rash and occasionally complications, including meningitis. The diagnosis of acute HIV infection syndrome (or primary HIV infection) is not established until the patient develops antibodies to HIV (i.e. seroconverts). This usually takes 3-6 weeks following the onset of the illness. Although the diagnosis of acute HIV infection syndrome may be strongly suspected at the time of discharge, it will not usually be confirmed at this time. Supportive evidence of acute HIV infection syndrome during the admission would include a positive HIV p24 antigen test. The possibility of acute HIV infection syndrome should have been recorded in the clinical record. A negative HIV antibody test during the admission does not exclude the diagnosis.

Where the diagnosis of 'acute HIV infection syndrome' (either confirmed or suspected) is documented, assign code *V01.7 Contact with or exposure to other viral diseases* as an additional diagnosis to the codes for the presenting symptoms (e.g. lymphadenopathy, fever) or complication (e.g. meningitis).

Infrequently, a patient may require re-admission for acute HIV infection syndrome due to complications. The principal diagnosis (e.g. meningitis (047.9)) should be coded first with acute HIV infection syndrome (*V01.7 Contact with or exposure to other viral diseases*) as the additional diagnosis.

After complete resolution of the primary illness, almost all patients will become asymptomatic and remain so for several years. Coding of future admissions would be determined by existing guidelines. The acute HIV infection syndrome code (V01.7) should not be used again once the patient has recovered from the primary illness.

When coders are unsure about the correct assignment from the available HIV codes (i.e. *795.71 Nonspecific serologic evidence of human immunodeficiency virus [HIV]*, V01.7 *Contact with or exposure to other viral diseases*, V08 *Asymptomatic human immunodeficiency virus [HIV] infection status*, or *042 Human immunodeficiency virus [HIV] disease*) for such cases, the clinician should be consulted.

It will be most helpful to begin coding these cases now, not only for clinicians and others interested in HIV, but also to allow easier transition into ICD-10 from July 1998 where this diagnosis is included as code B23.0.

(Coding Matters, Volume 2, No. 3, October 1995)

Acute pulmonary oedema

Acute pulmonary oedema is synonymous with left heart failure and should be coded to *428.1 Left heart failure* unless a respiratory condition is documented as the underlying cause.

(Coding Matters, Volume 1, No. 2, October 1994)

Acute pulmonary oedema

Clinical coders are reminded that if a patient with acute pulmonary oedema has coexisting heart failure or heart disease (as specified by the clinician), the diagnosis code to use will be from the 428 *Heart Failure* rubric. Please ensure that the lookup procedure for acute pulmonary oedema is followed carefully.

(Coding Matters, Volume 3, No. 4, April 1997)

Airway care – 96.55

The code 96.55 *Tracheostomy toilette* was chosen to represent 'airway care' by a physiotherapist consultant as there is no better existing code in ICD-9-CM to represent this procedural concept.

(Coding Matters, Volume 4, No. 2, October 1997)

Anaphylactic reaction to food

The NCCH has received a number of queries in regard to the use of 995.6x *Anaphylactic shock due to adverse food reaction* and the accompanying external cause code.The following points should be noted:

I. Anaphylaxis is an allergic hypersensitivity reaction of the body to a foreign protein or other substance. Substances most likely to produce anaphylaxis include:

- drugs, particularly antibiotics, local anaesthetics and codeine
- drugs prepared from animals, such as insulin, adrenocorticotropic hormone and enzymes
- diagnostic agents, such as iodinated X-ray contrast media
- biologicals used to provide immunity, such as vaccines, antitoxins and gamma globulin
- protein foods
- venom of bees, wasps and hornets
- pollens, moulds and animal dander

Anaphylaxis is not a poisoning

II. The exclusion note at E865 *Accidental poisoning from **poisonous** foodstuffs and poisonous plants* reads:

Excludes: anaphylactic shock due to adverse food reaction (995.6)
food poisoning (bacterial) (005.0–005.9)
poisoning and toxic reactions to venomous plants (905.6–905.7)

This note means that E865 cannot be used for anaphylactic shock due to adverse food reaction (995.6) because 995.6 is not an accidental poisoning. The same logic applies to food poisoning (005.0–005.9) and poisoning and toxic reactions to venomous plants (905.6–905.7). Note also the

addition of 'poisonous' to the category title (addendum 1996) which serves to reinforce the intention for this code to be used only for poisonings, not anaphylaxis.

III. The inclusion note at E930–E949 *Drugs, medicinal and **biological substances** causing adverse effects in therapeutic use* reads:

Includes: correct drug properly administered in therapeutic or prophylactic dosage, as the cause of any adverse effect including allergic or hypersensitivity reactions.

This note and the category title indicate that **biological substances causing allergic or hypersensitivity reactions** are included in E930 – E949.

IV. The index entry for 'Anaphylactic shock' in the external cause index (Volume 2, page 548) indicates that E947.9 *Unspecified drug or medicinal substance causing adverse effects in therapeutic use* is the correct code assignment. The *see also* 'Table of Drugs and Chemicals' note need not be followed as the entries in the Drug table for 'Food, foodstuffs, nonbacterial or noxious' (page 501) relates only to **poisoning by the noxious substance eaten as food**.

The correct external cause code assignment for 995.6x is E947.9 *Unspecified drug or medicinal substance causing adverse effects in therapeutic use.*

V. Anaphylactic reaction to food in ICD-10-AM

The same logic applies in ICD-10-AM for coding anaphylaxis due to food, i.e:

T78 **Adverse effects, not elsewhere classified**

T78.0 Anaphylactic shock due to adverse food reaction

DRUGS, MEDICAMENTS AND BIOLOGICAL SUBSTANCES CAUSING ADVERSE EFFECTS IN THERAPEUTIC USE (Y40–Y59)

Y57 **Other and unspecified drugs and medicaments**

Y57.9 Drug or medicament, unspecified, causing adverse effects in therapeutic use

(Coding Matters, Volume 4, No. 1, July 1997)

Apheresis and donation of stem cells

A number of queries have been received on the coding of stem cell procurement and the use of the apheresis code V58.6 and the stem cell donation code V59.02. The following guidelines provide clarity on previously published guidelines (*Coding Guidelines* 1994; *Australian Coding Standards* 0243 and 0301; *Coding Matters* Vol 3, No. 1, 1996 - see below):

Stem cell procurement and transplantation

For information about the technique of stem cell procurement and transplantation, please see ACS 0301 below. Note that 'apheresis' may also be documented in the clinical record as "peripheral blood stem cell collection" or "stem cell harvest" or similar.

Stem cells may be procured from:
1. A patient with a known malignancy, for therapeutic purposes (i.e. autologous donation), or
2. A healthy donor (nonautologous donation).

The relevant ICD-9-CM codes for this standard are:
V59.02 *Donors, blood, stem cells*
V58.6 *Apheresis*

Classification

Same day patients

Autologous donation	Same day patients (i.e. admitted and separated on the same date) undergoing autologous donation of stem cells should have a principal diagnosis code of V58.6 *Apheresis*. An additional code(s) should be assigned to indicate the condition/malignancy being treated. Clinical coders should note that this standard overrules the exclusion note relating to self-donation of organ or tissue under V59 *Donors*. Assign the appropriate procedure code, depending on whether the stem cells are frozen (cryopreservation): 99.75 *Procurement of stem cells with cryopreservation* 99.79 *Other therapeutic apheresis*
Nonautologous donation	Same day patients admitted as a donor for procurement of stem cells should have a principal diagnosis code of V59.02 *Donor, blood, stem cells*. Assign the appropriate procedure code, depending on whether the stem cells are frozen (cryopreservation): 99.75 *Procurement of stem cells with cryopreservation* 99.79 *Other therapeutic apheresis*

Multiday patients

Autologous	Multiday patients should have a principal diagnosis code of the condition/malignancy being treated and the appropriate procedure codes as mentioned above. Assignment of V58.6 *Apheresis* as an additional diagnosis code is unnecessary.

(Coding Matters, Volume 4, No. 3, January 1998)

Admission for plasmapheresis (superseded by Apheresis and donation of stem cells, page 3)

V58.6 Plasmapheresis

Plasmapheresis involves the separation of plasma from the solid components of blood by centrifugation. Toxic substances are discarded along with the plasma.

Plasmapheresis is undertaken in two circumstances:

- As part of the acute inpatient management of a patient with a severe neurological illess such as acute infective polyneuritis or myasthenia gravis. These patients are likely to have quite prolonged inpatient stay.

- Patients having long term plasmapheresis for haematological and immunological disorders and who are generally admitted as day only patients.

CODING STANDARD:

This code should only be used as the principal diagnosis for patients admitted specifically for plasmapheresis. The condition for which the plasmapheresis is being performed should be sequenced as the secondary diagnosis.

Patients who receive plasmapheresis during the course of their admission, ie. not admitted specifically for plasmapheresis, should have the appropriate procedure code assigned (99.71).

(Guidelines, '94)

Admission for stem cell or bone marrow procurement (ACS 0243) (superseded by Apheresis and donation of stem cells, page 3)

Stem cells and bone marrow may be procured from a patient with a known malignancy for therapeutic purposes (i.e. an autologous donation) or from a healthy donor.

Admission of a donor for procurement of stem cells should have a principal diagnosis code of V59.x *Donors* with a procedure code of either 99.75 *Procurement of stem cells with cryopreservation* or 99.79 *Other therapeutic apheresis* depending on whether or not the cells are frozen.

Admission of a patient with a malignancy for procurement, should have a principal diagnosis code for the malignancy (e.g. leukaemia, lymphoma) and one of the above procedures for procurement of stem cells or 41.91 *Aspiration of bone marrow from donor for transplant* for bone marrow harvesting. The V59.xx codes should not be assigned for patients with a malignancy making an autologous donation.

(Australian Coding Standards, July 1996)

Autologous haematopoietic stem cell transplant (ACS 0301) (superseded by Apheresis and donation of stem cells, page 3)

Autologous haematopoietic stem cell transplant may be accomplished by using haematopoietic stem cells obtained from either bone marrow or peripheral blood. Stem cell transplant may be performed on patients with breast cancer, Hodgkin s disease, Non-Hodgkin s lymphoma, multiple myeloma, or neuroblastoma (in children) where standard therapy would not cure these patients.

The bone marrow is the source of all blood cells and platelets. The bone marrow produces an immature, undifferentiated cell called a stem cell. This cell is not yet committed to differentiating into a specific cell type. At this stage, the stem cell is flexible and has the potential to become any one of the variety of mature blood cells. The specific cell type of the mature stem cell depends on which maturational pathway it follows. The patient undergoes apheresis in which the stem cells are

separated and retained. The plasma and the red blood cells are reinfused back into the patient. The patient then receives high dose chemotherapy and/or radiation treatment, according to the established protocol. Upon completion of the high dose of chemotherapy and/or radiation treatment, the stem cells which were retained are transplanted back into the patient.

The average length of stay for a patient who undergoes stem cell transplant is between 21 and 24 days. The technical management of a patient undergoing stem cell transplant is the same as a patient undergoing an autologous bone marrow transplant. The patient is placed in a bone marrow transplant room with around-the-clock intervention.

The recovery period for blood counts are within 9 to 11 days. This time frame is shorter than that of a bone marrow transplant, which places the patient at risk fo a shorter period of time. Mortality rate is less than 5 percent for stem cell transplant whereas for a bone marrow transplant, the rate is 7 to 15 percent. The patient is usually discharged 12 days after stem cell transplant.

Effective July 1995 there is an ICD-9-CM procedure code (41.04 *Autologous haematopoietic stem cell transplant*) to identify stem cell transplant. It should also be noted that the harvesting of stem cells is now indexed to code 99.79 *Therapeutic apheresis.*

Example 1:
If bone marrow and peripheral stem cells are transplanted during the same admission assign two codes: code 41.04, *Autologous haematopoietic stem cell transplant,* and code 41.01, *Autologous bone marrow transplant*.

Example 2:
When a patient undergoes apheresis only (where the stem cells are separated) assign code 99.79, *Therapeutic apheresis, Other,* which includes the harvesting of stem cells.

Example 3:
When a patient undergoes apheresis during an admission where the patient also receives high dose chemotherapy and/or radiation and the reinfusion of stem cells, assign two code(s); code 99.79, *Therapeutic apheresis,* and code 41.04, *Autologous haematopoietic stem cell transplant.*

(Guidelines '95)

Procurement of Stem Cells (superseded by Apheresis and donation of stem cells, page 3)

A new code has been created for "procurement of stem cells with cryopreservation" - 99.75.

(Coding Matters, Volume 3, No. 1, July 1996)

Bladder neck suspension

Review of the national morbidity data reveals a significant number of code 57.89 *Other repair of bladder* reported with a diagnosis of stress incontinence. There are two points which are important for coders to note:

- Code 57.89 cannot be used with a diagnosis of stress incontinence, in accordance with the exclusion note under category *57.8, Other repair of urinary bladder*, which reads:

  Excludes: that for stress incontinence
  (59.3 - 59.79)

- Bladder neck suspension and other similar procedures for the repair of stress incontinence are not classified well in ICD-9-CM. The NCCH has been working with the Obstetrics & Gynaecology Clinical Coding and Classification Group to improve this section for introduction from July 1996. As an interim guide, the following list is provided:

59.3 Plication of urethrovesical junction

Kelly (-Kennedy) operation (urethrovesical plication)
Kelly-Stoeckel operation (urethrovesical plication) (stitch)
Plication of urethrovesical junction

59.4 Suprapubic sling operation

Cystourethropexy by suprapubic suspension
Goebel-Frangenheim-Stoeckel operation (urethrovesical suspension)
Miller operation by urethrovesical suspension
Millin-Read operation (urethrovesical suspension)
Oxford operation for urinary incontinence
Sling operation, urethra (suprapubic)
Urethrocystopexy by suprapubic suspension
Repair of stress incontinence by suprapubic sling
Repair of stress incontinence by urethrovesical suspension

59.5 Retropubic urethral suspension

Aldridge (-Studdiford) operation (urethral sling)
Cystourethropexy by retropubic suspension
Sling operation, urethra (retropubic)
Sling operation, urethrovesical (retropubic)
Urethrocystopexy by retropubic suspension
Marshall-Marchetti (-Krantz) operation (retropubic urethral suspension)
Repair of stress incontinence by retropubic urethral suspension
Suspension urethral (retropubic) (sling)
Suture periurethral tissue to symphysis pubis
Burch colposuspension
Bladder neck elevation
Fixation, urethrovaginal (to Cooper's ligament)

59.6 Paraurethral suspension

Pereyra operation (paraurethral suspension)
Repair stress incontinence by paraurethral suspension
Repair stress incontinence by periurethral suspension
Suspension, paraurethral
Suspension, periurethral

59.71 Levator muscle operation for urethrovesical suspension

Cystourethropexy by levator muscle sling
Pubococcygeoplasty
Repair stress incontinence by cystourethropexy (with levator muscle sling)
Repair stress incontinence by pubococcygeal sling
Repair stress incontinence by urethrovesical suspension, levator muscle sling
Repair stress incontinence by urethrovesical suspension, gracilis muscle transplant
Urethrocystopexy by levator muscle sling
Inglemann Sundberg

59.79 Other repair of urinary stress incontinence

Cystourethropexy (NOS)
Kaufman operation (for urinary sress incontinence)
Insertion Rosen prosthesis for urinary incontinence
Operation for anti-incontinence NEC
Raz-Pereyra procedure (bladder neck suspension)
Stamey
Tudor 'rabbit-ear' (anterior urethropexy)
Repair stress incontinence by anterior urethropexy
Urethrocystopexy

70.77 Vaginal suspension and fixation

Colpopexy
Fixation, vagina
Harrison-Richards operation (vaginal suspension)
Norman-Miller operation (vaginopexy)
Suspension, vagina
Vaginofixation

(Coding Matters, Volume 2, No. 2, October 1995)

Blepharoplasty (ACS 0020 & 1205)

In the example on ACS 0020, **Exclusion criteria** paragraph b), blepharoplasty on both upper and lower eyelids of the same eye is excluded from double coding. In fact, this would involve two different procedure codes, 08.86 and 08.87 (as described in ACS 1205 BLEPHAROPLASTY) and it would therefore be necessary to assign both these codes. This example is included in the Errata for deletion.

(Coding Matters, Volume 2, No. 1, July 1995)

Brachial neuritis

When a diagnosis of *Brachial neuritis* (723.4) or *Cervicobrachial syndrome* (723.3) is supplied by the clinician, coders should seek to discover whether the condition is due to *Intervertebral disc disorder* (722.x) or due to *Spondylosis* (721.x). Clinical coders are reminded of the exclusion note that exists under the 723 rubric which prevents the use of this code when the condition is due to spondylosis or disc disorder. It is important to follow this exclusion note, as failure to do so may cause patients undergoing laminectomy and/or discectomy to group to an incorrect AN-DRG.

(Coding Matters, Volume 3, No. 3, January 1997)

Breast reconstruction – 85.7x (ACS 1212)

New codes have been created for breast reconstruction when performed post mastectomy. The category 85.7 Reconstruction of breast includes:

85.71 *Pedicle flap to breast, post mastectomy*

85.72 Myocutaneous flap to breast, post mastectomy

85.73 Unilateral breast implant, post mastectomy

85.74 Bilateral breast implant, post mastectomy

85.75 Total reconstruction of breast, post mastectomy

85.79 Other total reconstruction of breast

(Coding Matters, Volume 3, No. 1, July 1996)

Browplasty – 86.87

This procedure is classified under the new code 86.87 *Forehead rhytidectomy*.

(Coding Matters, Volume 3, No. 1, July 1996)

Campylobacter – 041.89

Campylobacter infestation can occur (rarely) outside the gastrointestinal tract, specifically in the meninges, gall bladder, as vascular infection, bacteraemia and abscesses and causing peritonitis in patients with chronic renal failure on renal dialysis. The code for the organism in these cases should be 041.89 *Other specified bacterial infection,* and sequenced as a secondary diagnosis code to the principal diagnosis.

(Coding Matters, Volume 2, No. 1, July 1995)

Cardiac biopsy via catheterisation (ACS 0023)

This query from the Victorian ICD Coding Committee is included here for your information:

Query
'Patients are admitted for cardiac biopsy following a heart or heart lung transplant. This procedure is performed to monitor the levels of rejection post transplant and is performed via a right catheter. Most biopsies show some level of rejection and these cases are currently assigned the following codes: 996.83, V42.1, 37.25 and 37.21. Adding 37.21 would more appropriately reflect the complexity and diagnostic nature of this procedure.'

The Victorian ICD Coding Committee agreed that code *37.21 Diagnostic procedures on heart and pericardium, right heart cardiac catheterisation* should be added to the codes already assigned, to reflect the approach used in obtaining the biopsy (in keeping with the intent of ACS 0023 Laparoscopic/
arthroscopic/endoscopic surgery). Code V42.1 is not needed with code 996.83.

The recommended codes are:

996.83	*Complication of transplanted organ, heart*
E878.09	*Surgical operation and other surgical procedures as the cause of abnormal reaction of patient, or of later complication, without mention of misadventure at the time of operation, surgical operation with transplant of whole organ*
37.25	*Biopsy of heart*
37.21	*Right heart cardiac catheterisation.*

NCCH comment
The NCCH agrees with the Victorian ICD Coding Committee that this approach is consistent with ACS 0023.

(Coding Matters, Volume 3, No 3, January 1997)

Change of burns dressing (ACS 1911)

Note that in ACS 1911 BURNS - Admission for change of burn dressing, the burn should be coded as a secondary condition to the principal diagnosis of V58.3 *Attention to surgical dressing and sutures.*

(Coding Matters, Volume 2, No. 1, July 1995

Chemotherapy – V58.11

While most oral chemotherapy will be given on an outpatient basis, there will be rare occasions where the patient is admitted. An admission for oral chemotherapy should be assigned the principal diagnosis of V58.11 *Chemotherapy, parenteral, NOS.*

(Coding Matters, Volume 2, No. 1, July 1995)

Chronic obstructive pulmonary disease (COPD) (ACS 1008)

Dr Christopher Clarke (Respiratory CCCG) and Kerry Innes presented a joint paper on Respiratory Medicine and Clinical Coding at the recent 1996 NCCH Seminar in Coolum Queensland. Some important points from their presentation about COPD are included here.

Note: The video of this presentation is available from the NCCH for $25

- Chronic obstructive pulmonary disease (COPD) is the current preferred terminology, with chronic obstructive airways disease (COAD) and chronic airway limitation (CAL) being synonymous terms.
- Documentation of 'COPD' may relate to any of the following codes in ICD-9-CM depending on the underlying condition. Coders should therefore check the record thoroughly to abstract the appropriate information about the following conditions:

  Chronic asthmatic bronchitis – 491.2x
  Chronic emphysematous bronchitis – 491.2x
  Chronic bronchitis with airway obstruction – 491.2x
  Obstructive asthma – 493.2x
  Chronic obstructive pulmonary disease – 496
  Emphysema (obstructive) – 492.8

These are all regarded clinically as COPD as they are all 'obstructive' in nature.

The schema of COPD reproduced on page 15 has been adapted from: American Thoracic Society. 'Standards for the diagnosis and care of patients with chronic obstructive pulmonary disease.' *Am J Respir Crit Care Med* 1995 (Suppl): S77-S120. This is a particularly good article and is highly recommended further reading.

An important feature of the COPD classification in ICD-9-CM is that 496 is regarded as a 'last resort'. The specific conditions resulting in the obstruction are assigned in preference to 496, if known (see the exclusion note at 496).

In contrast, this is **not** a feature of ICD-10-AM: J44 **includes** all the various conditions, such as asthma, chronic bronchitis and emphysema when described as 'obstructive'.

Another good feature of ICD-10-AM is the inclusion of codes for 'COPD with acute lower respiratory infection' and 'COPD with acute exacerbation, unspecified'.

Exercise
Read through the inclusion and exclusion notes below from J44 in ICD-10-AM and note the way in which these conditions are classified differently from ICD-9-CM:

J44 Other chronic obstructive pulmonary disease

Includes: chronic:
- bronchitis:
  - asthmatic (obstructive)
  - emphysematous
  - with:
    - airways obstruction
    - emphysema
- obstructive:
  - asthma
  - bronchitis
  - tracheobronchitis

Excludes: asthma (J45.-)
asthmatic bronchitis NOS (J45.9)
bronchiectasis (J47)
chronic:
- bronchitis:
  - NOS (J42)
  - simple and mucopurulent (J41.-)
- tracheitis (J42)
- tracheobronchitis (J42)

emphysema (J43.-)
lung diseases due to external agents (J60-J70)

J44.0 Chronic obstructive pulmonary disease with acute lower respiratory infection

J44.1 Chronic obstructive pulmonary disease with acute exacerbation, unspecified

(Coding Matters, Volume 3, No. 3, January 1997)

Colonoscopy with ileal biopsy (ACS 1114)

There is no specific code for this procedure in ICD-9-CM. The index will lead to two codes, one for the colonoscopy (45.23 *Colonoscopy*) and one for the closed biopsy of the small intestine (45.14 *Closed [endoscopic] biopsy of small intestine*).

The incongruity of these two codes is clear, in that the biopsy of ileum is classified to a code which is normally associated with **upper** gastrointestinal endoscopy (namely, gastroscopy).

When coding 'colonoscopy with ileal biopsy', assign only the code 45.25 *Closed [endoscopic] biopsy of large intestine*. Note that the subterms at 45.25 includes 'colonoscopy with biopsy'.

(Coding Matters, Volume 4, No. 1, July 1997)

Coloproctectomy

This term is not indexed in ICD-9-CM but an exclusion note exists under code 45.8 which has caused some confusion. It reads:

Excludes: coloproctectomy (48.41 – 48.69)

This exclusion note is incorrect, and should be ignored. Because ICD-9-CM differentiates between procedures on the colon and the rectum, coloproctectomy should be assigned two codes, namely:

45.8 Total intra-abdominal colectomy, and
48.5 Abdominoperineal resection of rectum

(Coding Matters, Volume 2, No. 4, April 1996)

Confusion in Parkinson's disease

Confusion is not a normal feature of Parkinson's disease and should be coded as a secondary condition if documented

(Coding Matters, Volume 2, No. 1, July 1995)

Coronary artery bypass grafts (CABGs) (ACS 0909)

There has been some confusion about the number of grafts that should be coded when a left internal mammary artery (LIMA) is involved, which is discussed in the first paragraph of the standard. The important thing to remember when coding CABGs is that it may be documented as 'CABGx4' but the coder should always check if a LIMA is involved, as this will reduce the number of 'CABGs' coded. If a LIMA is performed in a procedure documented as 'CABGx4' then a code for CABGx3 should be assigned with an additional code for the LIMA.

(Coding Matters, Volume 3, No. 1, July 1996)

Coronary atherectomy

Changes to the Volume 3 index and tabular have been made to include coronary atherectomy procedures (rotational, laser, directional) with percutaneous transluminal balloon angioplasty.

For example:

	36.01	Single vessel percutaneous transluminal coronary angioplasty [PTCA] <u>or coronary atherectomy</u> without mention of thrombolytic agent
Add		<u>Coronary atherectomy</u>
Delete		~~That by laser~~
Amend exclusion term		***Excludes:*** *multiple vessel percutaneous transluminal coronary angioplasty <u>[PTCA] or coronary atherectomy</u> performed during the same operation (36.05)*

(Guidelines '95)

Dementia NOS (ACS 0504) – effective 1 July 1996

'Dementia, NOS' was discussed at the Geriatrics & Rehabilitation CCCG meetings in 1995, and clinical advice was that dementia without further qualification should not be coded to either senile or presenile.

Accordingly, coders should follow the index from July 1996 and assign code 294.8 *Other specified organic brain syndromes (chronic).*

In Australian Coding Standard 0504 Dementia, the first paragraph should be deleted (*see* Errata):

~~**'Senile and Pre-Senile Dementia'**~~
~~'Dementia NOS' should be coded to senile dementia unless specified as pre-senile dementia. Pre-senile dementia should only be recorded when specifically stated.~~

(Coding Matters, Volume 3, No. 1, July 1996)

Diabetes mellitus

If a noninsulin dependent (NIDDM) patient is admitted and treated with insulin then the coder should assume that the diabetes is uncontrolled

Portacaths are used rarely for insulin infusion or nutritional purposes. It could occur as an incidental procedure for diabetic patients with malignancy.

(Coding Matters, Volume 2, No. 1, July 1995)

Diabetic peripheral autonomic neuropathy and diabetic eye changes (ACS 0401)

Clinical coders are reminded that the diabetes code should always be sequenced before the manifestation code [*see* ACS 0401, page 56, Volume 4, 1996].

Thus 250.6x *Diabetes with neurological complications* should be sequenced before 337.1 P*eripheral autonomic neuropathy*, and 250.5x *Diabetes with ophthalmic complications* should be sequenced before 366.41 *Diabetic cataract.*

(Coding Matters, Volume 3, No. 3, January 1997)

Dialysis (ACS 1404)

The Coding Standards Advisory Committee discussed the coding of overnight dialysis patients at the meetings on 31 March and 30 June, 1995. Initially, the committee members recommended that overnight dialysis admissions should be coded with V56.0 as the principal diagnosis rather than the condition which requires the patient to stay overnight, as stated in ACS 1404. However, it was agreed that the existing standard (ACS 1404) should be used from July 1995 until further data analysis of intended sameday overnight cases is available.

(Coding Matters, Volume 2, No. 1, July 1995)

Duration of pregnancy codes with early onset of delivery (ACS 1518)

The V23.6x codes are intended for use only with high risk pregnancies (e.g. abortion, threatened premature labour) as stated in ACS 1518 **Duration of Pregnancy**. However, from July 1997 V23.6x *Duration of pregnancy* codes can be assigned with 644.21 *Early onset of delivery*.

(Coding Matters, Volume 4, No. 1, July 1997)

Ear, nose and throat (ENT)

Chronic sinusitis

Clinical coders should seek more information from clinicians about which sinuses are chronically inflamed. Ethmoidectomy is the most frequently coded procedure to treat chronic sinusitis, and therefore it may be that the ethmoidal sinus is the one chronically inflamed. Check with the clinician to determine if this assumption is correct.

Sialoadenectomy

The most frequently used procedure code for sialoadenectomy is 26.30 *Sialoadenectomy, not otherwise specified*. This non-specific code, a commonly occurring problem in editing software, is a constant source of query to private hospitals from health funds.

Clinical coders should be encouraged to ask the surgeon whether or not the procedure performed is a complete or partial sialoadenectomy, and use those codes when appropriate.

Cleft palate

Again, the most frequently used code is 749.00 *Cleft palate, unspecified*. Clinical coders should attempt to obtain more specificity from the surgeon.

Rhinoplasty (ACS 0806)

Australian Coding Standard 0806 (Volume 4, page 84) states that 'Procedures on turbinates are often performed in conjunction with a rhinoplasty or septoplasty as part of the operative approach, therefore, codes from category 21.6 *Turbinectomy* need not be assigned in this circumstance.'

Clinical coders are encouraged to discuss the issue of coding (or not coding) turbinectomies with their ENT and Plastic Surgeons.

(Coding Matters, Volume 3, No. 4, April 1997)

Elective removal of breast implants (ACS 1206)

Subsequent to this standard being published, the Plastic Surgery CCCG members agreed that V52.4 Fitting and adjustment of prosthetic device (which includes removal of the device) should be used as principal diagnosis, rather than the reasons for removal, which are often not documented int he clinical record. If the reason for removal of breast implants is known, this should be assigned as a secondary condition code.

(Coding Matters, Volume 2, No. 1, July 1995)

Elevated prostate specific antigen (PSA) (ACS 1414)

Note that in ACS 1414 ELEVATED PROSTATIC SPECIFIC ANTIGEN (PSA), elevated PSA would only be coded when documented as clinically significant.

(Coding Matters, Volume 2, No. 1, July 1995

Endarterectomy

Clinical coders should remember that there is no need to code any vessel patch graft occurring during *Endarterectomy* (38.1x), as the graft is already included within the endarterectomy code.

(Coding Matters, Volume 3, No. 3, January 1997)

Excision of eyelid lesion

Clinical coders are encouraged to seek more detail on whether lesions of eyelids are considered 'minor' (08.21-08.22 *Excision of minor lesion of eyelid*) or 'major' (08.23-08.24 *Excision of major lesion of eyelid, partial or full-thickness).* Databases suggest that malignant skin lesions are often coded as 'minor' lesions, when they may be 'major' lesions. Clinical coders are advised to check the size of the lesion and the extent of the excision with the surgeon. Failure to clarify these points may result in patients being grouped into an inappropriate DRG.

(Coding Matters, Volume 3, No. 3, January 1997)

Exploration of abdominal wall for undescended testis

In the first instance, exploration is necessary to ascertain whether there is an undescended testis in the abdominal cavity. This procedure would normally not be coded (54.11 *Exploratory laparotomy*) as the exclusion note instructs the coder to omit this code when the exploratory laparotomy is incidental to intra-abdominal surgery. In cases of undescended testis, however, the exploration is performed independently of the orchiopexy (62.5) to establish whether there is in fact an undescended testis in the abdominal cavity. In these cases, code the orchiopexy (62.5) as the first procedure, followed by the exploratory laparotomy (54.11) or only 54.11 if no testis is found. (Nephrology and Urology CCCG, March 1995).

(Coding Matters, Volume 1, No. 4, April 1995)

External cause codes

New codes have been created for:

Fall on or from footpath kerb	E880.1
Fall from chair	E884.2
Fall from tree	E884.3
Fall involving bed	E884.4
Fall from trampoline	E884.5
Fall involving wheelchair	E884.6
Fall involving commode	E884.7
Drowning and submersion while in swimming pool	E910.5
Drowning and submersion following fall into swimming pool	E910.6
Drowning and submersion following fall into natural water	E910.7
Maltreatment by spouse or partner	E967.2
Maltreatment by acquaintance or friend	E967.3

A new category for type of sporting activity E889.x should be used in conjunction with the principal E code for the type of injury. This category will not only provide valuable information about sporting injuries but will also provide continuity in the changeover to ICD-10 where this concept is included.

A new code has been created for accidents caused by hot tap water, E924.2.

(Coding Matters, Volume 3, No. 1, July 1996)

Failed forceps and failed vacuum extraction (ACS 0019)

Disease and procedure coding varies for failed forceps/vacuum extraction due to the structure of ICD-9-CM.

Whenever a diagnosis of 'failed forceps' or 'failed vacuum extraction' is documented, assign 660.7x Failed forceps or vacuum extraction, unspecified with the appropriate procedure code.

If the procedure is failed forceps, assign 73.3 Failed forceps only. A code for the specific type of forceps is unnecessary. When using 73.3 ensure that a code for episiotomy is assigned if this is also performed. If the procedure is 'failed vacuum extraction', code to the appropriate vacuum extraction code (72.7x) as no specific code exists for 'failed vacuum extraction'. In cases of failed forceps/vacuum extraction an additional code is required for any subsequent intervention e.g. caesarean.

(Coding Matters, Volume 2, No. 4, April 1996)

Fitting and adjustment of catheters – V56.1, V58.81 and V58.82

These codes are for use when identifying encounter for care (such as removal or cleaning) of dialysis or nonvascular catheters that are unrelated to a specific disease. The description of code V58.81 has been revised so this code includes any fitting or adjustment of a vascular catheter (not just removal). The fitting and adjustment codes should not be assigned for catheter complications, dialysis preparation, or dialysis encounters.

(Coding Matters, Volume 3, No. 1, July 1996)

Functional endoscopic sinus surgery (FESS) (ACS 0807)

Sinoscopy (22.19) is routinely performed in this procedure and should be coded when FESS is documented. Note inclusion in the Errata.

(Coding Matters, Volume 3, No. 1, July 1996)

Grafts and flaps (ACS 1215)

The following information is provided, courtesy of the Royal Melbourne Hospital Coding Committee and Mr. Bruce Johnstone, a member of the Plastic Surgery CCCG.

GRAFT A graft is separated from its blood supply and placed in its new position. A new blood supply then establishes itself. Skin grafting is a good example.

A **full thickness graft** is a layer of skin plus all of the underlying dermis.

A **split skin graft** is a piece of skin shaved off with the top of the dermis, leaving a defect very similar to a gravel rash which then heals naturally.

FLAP A flap has its own blood supply.

A **free flap** is raised from the donor site comlete with blood vessels which are then anastomosed to the blood vessels at the recipient site under a microscope.

A **pedicle flap** is raised from the donor site with the major blood vessels still attached at the donor site via a 'pedicle'. The flap is then rotated, advanced or transposed to the new site.

A **delayed flap** is raised from the donor site as a pedicle flap but it is left 'resting' in the donor site for a few days or week before it is placed in its new site. This allows the blood supply in the flap to strengthen before it is moved, thus increasing the flap's chances of survival.

CODING When coding flaps it is possible that codes *86.71 Cutting and preparation of pedicle grafts* or flaps, *86.72 Advancement of pedicle graft, 86.73 Attachment of pedicle or flap graft to hand* and *86.74 Attachment of pedicle or flap graft to other sites* could all be used for the one operative episode. If it is a delayed flap then *86.71* may be used at the first operative episode and *86.72, 86.73* and *86.74* may be used at the second operative episode.

It is important to remember to code *39.50 Microvascular tissue transfer* when the vessels are anastomosed under the microscope.

(Coding Matters, Volume 2, No. 1, July 1995)

Grover's disease

Grover's disease is an acquired, monomorphous, papulovesicular eruption of unknown cause first characterized by Ralph W. Grover in 1970[1]. Grover's disease is also known as transient acantholytic dermatosis.

[1] *Jerome Michael Parsons. Transient acantholytic dermatosis (Grover's disease): A global perspective. J Am Acad Dermatol* 1996;35: 653-666.

Coding

ICD-9-CM *702.8 Other specified dermatoses*

[ICD-10-AM*: L11.1 Transient acantholytic dermatosis [Grover]*]

(Coding Matters, Volume 4, No. 2, October 1997)

Head injury/concussion (ACS 1905)

Those coders who have used *'Getting it Right in Paediatric Coding'* will realise that the standard on head injury in that document is different to the *Australian Coding Standard* 1905. **The classical definition of concussion is head injury with a loss of consciousness**. The neurosciences and paediatric CCCG members have agreed that the current *Australian Coding Standard* should apply with some minor modifications recommended for July 1996, which includes an exclusion note under the section 854, indicating that any head injury which involves concussion should be coded to either a specific code from 851-853 with an appropriate fifth digit for the loss of consciousness or to 850 when no specificity about the type of head injury is documented.

(Coding Matters, Volume 2, No. 1, July 1995

Hindwater leak

Q: Should 'hindwater leak' be coded as a premature rupture of membranes?

A: Yes - assign the appropriate code from 658.1x, 658.2x, 658.5x Premature rupture of membranes . . . If an Artificial rupture of membrane (ARM) is subsequently performed on the forewaters this should be coded (*73.0x Artificial rupture of membranes).*

(Coding Matters, Volume 4, No. 2, Oct 1997)

Hyperbaric oxygenation

Thanks to Dr. Mike Bennett, Medical Director, Department of Diving and Hyperbaric Medicine, The Prince of Wales Hospital, Sydney for assisting the NCCH in the preparation of coding standards for hyperbaric oxygenation. Following is an extract from the Prince of Wales Hospital's *Handbook of Diving and Hyperbaric Medicine*, February 1996:

'Hyperbaric oxygen (HBO) therapy involves the intermittent inhalation of 100% oxygen under pressures greater than one atmosphere. This treatment is carried out in a high pressure vessel called variously a hyperbaric chamber, recompression chamber or decompression chamber.

Hyperbaric therapy has long been accepted as the definitive treatment for decompression illness (DCI) and much of the terminology and traditional framework surrounding this form of therapy continues to reflect these historical origins. Re-pressurisation with air was first proposed by Paul Bert in 1873 as being the most appropriate treatment for workers suffering mysterious illnesses subsequent to work under hyperbaric conditions.

A variety of conditions respond well to hyperbaric therapy. They are: decompression illness, cerebral arterial gas embolism, carbon monoxide poisoning, Clostridial myonecrosis, osteoradionecrosis and chronic refractory osteomyelitis.

Other conditions for which there is increasing experimental and some clinical evidence of efficacy are: thermal burns, problem wounds (especially diabetic), other myonecroses (e.g. Fourniers gangrene), compromised flaps and grafts, cyanide poisoning, soft tissue radionecrosis, brain injuries and xerostomia.'

Coding
There are three ICD-9-CM codes which, according to national morbidity data, have been variously used to describe hyperbaric oxygenation. The use of these codes is clarified as follows:

93.95 Hyperbaric oxygenation

This code should be assigned for **all** hyperbaric oxygenation. The exclusion note 'oxygenation of wound (93.59)' relates only to those small number of cases where a plastic bag is used to enclose a wound and oxygen is pumped into the bag.

93.59 Other immobilisation, pressure, and attention to wound

This code should never be used for hyperbaric oxygenation unless the exclusion note under 93.95 applies.

93.97 Decompression chamber

This code should **never** be used as 'decompression chamber' is synonymous with hyperbaric oxygenation (see explanatory notes above).

(Coding Matters, Volume 3, No. 1, July 1996)

Hypertension, a refresher on coding types of (ACS 0925)

The categories 401 *Essential hypertension, 402 Hypertensive heart disease, 403 Hypertensive renal disease* and *404 Hypertensive heart andrenal disease* can be confusing, so without reiterating Australian Coding Standard ACS 0925 (page 86, Volume 4), here are a few tips on how to assign these codes correctly:

I. These codes are mutually exclusive, i.e. you can assign **only one of them to one episode of care**.

Example
Hypertensive congestive cardiac failure

☑ Correct coding

402.91 *Hypertensive heart disease, unspecified, with congestive cardiac failure*

☒ Incorrect coding

402.91 *Hypertensive heart disease, unspecified, with congestive cardiac failure*
401.9 *Essential hypertension unspecified*

– This code is unnecessary

II. 401.x *Essential hypertension* should be assigned only when there are no documented conditions related to the hypertension.

III. Categories 402, 403 and 404 are used when there is a **documented causal relationship between the hypertension and the condition.** Examples of how this causal relationship could be documented in the record are:

'Hypertensive heart disease'
'Hypertensive renal disease'
'Hypertensive heart and renal disease'
'Renal disorder due to hypertension'
'Malignant hypertension with associated nephropathy and CCF'

IV. It is not necessary to assign an additional code for categories 402, 403 or 404 to indicate the condition related to the hypertension.

Example
Diagnosis: Hypertensive cardiomegaly

Code: 402.90 *Hypertensive heart disease, unspecified, without congestive heart failure*

The code for cardiomegaly (429.3) is not necessary as this condition is included in code 402.90 (*see* Index: 'Cardiomegaly, hypertensive').

(Coding Matters, Volume 4, No. 1, July 1997)

Hyphaema (ACS 0732)

Coders are reminded that all haemorrhages occurring post-ophthalmic surgery should be coded to 364.41 *Hyphaema*, and not to 998.1 *Haemorrhage or haematoma complicating a procedure.*

(Coding Matters, Volume 3, No. 3, January 1997)

Infection of peritoneal catheter (ACS 1425)

ACS 1425 INFECTION COMPLICATING TENCKHOFF CATHETER instructs the coder to assign 996.62 *(Infection) due to other vascular device, shunt, and graft,* however, this code is incorrect as Tenckhoff catheters are peritoneal, not vascular catheters. A new code specifically for infections of peritoneal dialysis catheter will be introduced in 1996. Until then, assign code 996.73 *Other complications due to renal dialysis device, imlant, and graft* with peritonitis 567.2 *(generalised peritonitis)* as a secondary diagnosis if applicable. E879.1 *Kidney dialysis as the cause of abnormal reaction of patient, or of later complication* should also be assigned.

(Coding Matters, Volume 2, No. 1, July 1995

Injection of 5FU at trabeculectomyand/or cataract extraction

5FU and Mitomycin C are used as antifibrotics either intra or postoperatively in trabeculectomy or cataract extraction. The antimitotic properties help to reduce postoperative fibrosis (reducing fibroblast proliferation). Mitomycin C is applied intraoperatively (usually for one minute).

5FU is typically given over a number of courses during the immediate postoperative period (up to three weeks or so). The typical dose of 5FU is 5mg, injected subconjunctivally with topical anaesthetic plus antibiotic cover. Usually the needle is placed through the conjunctiva from a temporal approach. Code subconjunctival injection of 5FU to 10.91 *Subconjunctival injection.*

(Coding Matters, Volume 3, No. 3, January 1997)

Intracranial injury – 850–854 (ACS 1905)

The fifth digit of '9' has been deleted from the list for these codes to bring the classification in line with the coding standard 1905 CLOSED HEAD INJURY/CONCUSSION. As concussion is defined as a head injury with loss of consciousness, codes 850.0 Concussion with no loss of consciousness and 850.5 Concussion with loss of consciousness of unspecified duration have been deleted. Therefore, all head injuries with concussion should be coded to 850–853 as follows:

1. No injury classifiable to 851–853 is present (assign 850)

2. Cerebral laceration or contusion (assign 851)

3. Cerebral haemorrhage (assign a code from 852 or 853)

Category 854 *Intracranial injury of other and unspecified nature* should be used rarely and when used, should only have a fifth digit of '1' as any head injury with loss of consciousness (fifth digits of 2–6) is classified to 850–853.

(Coding Matters, Volume 3, No. 1, July 1996)

Intragam (ACS 0214)

ACS 0214 INTRAGAM advises coders to assign the code 279.00 *Hypogammaglobulinaemia* as the principal diagnosis for patients admitted specifically for injection of Intragam. A number of clinical coders queried why code V07.2 was not assigned as the principal diagnosis in these cases. This decision is based on the fact that V07.2 is appropriate for prophylactic (i.e. preventative) treatment to treat a potential condition/illness, whereas Intragam is being given therapeutically to treat the active/current condition of hypogammaglobulinaemia.

(Coding Matters, Volume 2, No. 1, July 1995)

Intravenous neurolepsis

Children admitted for chemotherapy may have intravenous neurolepsis as part of that treatment. Assign 99.26 *Injection of tranquilliser* as a secondary procedure code to the chemotherapy.

(Coding Matters, Volume 2, No. 2, October 1995)

Kaposi's sarcoma (ACS 0102)

It has been noted in the national data that the unspecified code for Kaposi's sarcoma 176.9 is more frequently used than the more specific codes in this category 176. Coders should attempt to abstract the exact site/s for this condition.

(Coding Matters, Volume 2, No. 2, October 1995)

Keratoacanthoma

We have been inundated with queries about the correct M code for keratoacanthoma (238.2). The Royal College of Pathologists of Australasia has advised us that M8070/1 is the best available code. If you have been using a different M code then you should change to M8070/1 from July 1996.

(Coding Matters, Volume 3, No. 1, July 1996)

LeFort operation of the vagina

Obliteration of Cul-de-sac

Repair of Vaginal Enterocele

Changes to the index and tabular to correctly assign LeFort operation of the vagina, Obliteration of the cul-de-sac, and Repair of vaginal enterocele, have been made.

The LeFort operation of the vagina is a procedure performed to unite the anterior and posterior vaginal walls along the middle line for the repair of prolapse of the uterus. This involves an obliteration (complete removal) of the vaginal vault ("arched" area between the vaginal wall and the vaginal part of the cervix) not the vagina. A LeFort operation of the vagina is to be assigned code 70.8 *Obliteration of vaginal vault*.

The cul-de-sac is the space between the uterosacral ligaments anterior to the rectum and posterior to the cervix. This area prevents prolapse of the uterus. The cul-de-sac is used for diagnostic exploration of the pelvis via the vagina. The obliteration of the cul-de-sac does not involve the vaginal vault. Therefore, code assignment has been changed to code 70.92 *Other operations on cul-de-sac*.

A vaginal enterocele develops when there is weakness in the area of the cul-de-sac. A portion of the vaginal wall descends, accompanied by the small bowel. Repair of the vaginal enterocele entails dissection of the sac and may include obliteration of the cul-de-sac. The repair of the vaginal enterocele does not involve obliteration of the vaginal vault. Code assignment for the repair of vaginal enterocele is now indexed to code 70.92 *Other operations on cul-de-sac*.

(Guidelines '95)

Lennox-Gastaut syndrome (ACS 0623)

Although a patient with this syndrome may suffer from a specific type of seizure (e.g. tonic, tonic-clonic, akinetic), the type of seizure should not be used to code these cases. Lennox-Gastaut Syndrome is categorised in ICD-9-CM to 345.0 *Generalised nonconvulsive epilepsy* and is appropriate and adequate to describe the syndrome.

(Coding Matters, Volume 2, No. 2, October 1995)

Limbal stem cell transplantation

The junctional zone between the corneal and conjunctival epithelia is known as the limbus. It is believed that the basal epithelial cells of the limbus include the stem cells for corneal epithelial proliferation and differentiation. In cases of corneal scarring, chemical or thermal burns and other long-term ocular surface failures, conjunctival transplantation including limbal epithelium results, in many cases, in restoration of the corneal epithelial phenotype.

The procedure involves the transfer of grafts of limbal tissue from the uninjured eye to the injured eye. The limbal tissue can also be obtained from a donor eye.

Coding

ICD-9-CM:	*11.69*	*Other corneal transplant*
[ICD-10-AM:	*90065-00*	*Limbal stem cell transplant]*

(Coding Matters, Volume 4, No. 2, October 1997)

Lung volume reduction surgery – 32.22

This procedure is performed for selected patients with chronic obstructive pulmonary disease or emphysema. Twenty to thirty percent of the volume of each lung is excised. Reducing the size of the patient's lungs gives the patient more room to breathe. In emphysema, the air sacs in the lungs become unnaturally enlarged, the lung tissue loses elasticity, and the lungs are unable to expand and contract normally.

(Coding Matters, Volume 3, No. 1, July 1996)

Mechanical ventilation

- Mechanical ventilation and intubation for neonates, regardless of duration or means of administration should be coded.
- Do not code intubation for adults, if mechanical ventilation duration is <25 hours

(Coding Matters, Volume 2, No. 1, July 1995)

Mechanical ventilation of the newborn (ACS 1006)

Subsequent to advice published in *Coding Matters, Vol 2, No.1, page 15* (namely, that 'mechanical ventilation and intubation for neonates, regardless of duration or means of administration should be coded'), the issue of coding mechanical ventilation for neonates has recently been discussed by the Neonatal Subcommittee of the Paediatric Clinical Coding and Classification Group (CCCG). The neonatologists advised that mechanical ventilation for neonates for a period of <25 hours **should not** be coded, in order that consistency is achieved in the coding of ventilation for both adults and children.

My apologies for the confusion that this issue has caused. As a result of the previous advice to code ventilation for neonates, many coders began using 96.70 to reflect this treatment.

However, this subsequent decision means that code *96.70 Continuous mechanical ventilation of unspecified duration* should never be assigned.

(Coding Matters, Volume 2, No. 3, January 1996)

Meniscus/ligament tear, NOS (ACS 1319 & 1906)

There was much debate at the ACS workshops about whether we need this standard given the new definitions for 'current' and 'old' injury (ACS 1906). The Coding Standards Advisory Committee will be considering this issue at its next meeting. Until a decision is made, coders should use the rule for meniscus/ligament tears as stated in ACS 1319 (code to 'old' unless stated as 'current') and apply the definitions of 'current' and 'old' in ACS 1906 for all other injuries.

(Coding Matters, Volume 2, No. 1, July 1995)

Mesenteric adenitis (ACS 1111)

ACS 1111 should be ignored until further notice as this standard was intended to address the problem below but fails to do so as it is currently written:

A patient is admitted with abdominal pain, undergoes an appendicectomy, the histopathology of the appendix is normal and mesenteric adenitis is noted on the operation report. Should the mesenteric

adenitis be sequenced as the prinicpal diagnosis based on the assumption that the adenitis caused the pain?

There has been some clinical disagreement about the answer to this question and we will advise you when this is clarified.

(Coding Matters, Volume 2, No. 1, July 1995)

Morphology coding refresher

Thanks to Dr Bruce Armstrong, Director, Cancer Control Information Centre and Noreen Panos, Data Manager, NSW Central Cancer Registry for providing these concise notes on the meaning and application of the one-digit behaviour codes, in particular /1 and /2, of the morphology codes.

The morphology code numbers consist of five digits:
- the first four identify the histological type of the neoplasm
- the fifth indicates its **behaviour**.

The one-digit behaviour code is as follows:

/0 Benign
/1 Uncertain whether benign or malignant
Borderline malignancy★
/2 Carcinoma in situ
Intraepithelial★
Noninfiltrating★
Noninvasive★
/3 Malignant, primary site
/6 Malignant, metastatic site
Secondary site
/9 Malignant, uncertain whether primary or metastatic site

Important principle in assignment of the behaviour codes

The introduction of the morphology chapter in Volume 1 of ICD-9-CM, page 371, states:

'the morphology code numbers include the behaviour code appropriate to the histological type of neoplasm ***but this behaviour code should be changed if other reported information makes this necessary****'*.

For example, 'chordoma' (M9370/3) is assumed to be malignant in ICD-9-CM. However, if the pathologist states a behaviour different from the usual behaviour as given in ICD-9-CM, code as the pathologist indicates.

/1 Uncertain whether benign or malignant

Uncertain whether benign or malignant and *Borderline malignancy* are synonymous terms. Please use behaviour code /1 if any of these terms are used in a pathology report to describe a neoplasm **even though the index may not include all these terms**.

/2 Carcinoma in situ

Carcinoma in situ, intraepithelial carcinoma, noninfiltrating carcinoma and *noninvasive carcinoma* are synonymous terms. Assign behaviour code /2 if any of these terms are used in a pathology report to describe a neoplasm **even though these terms may not appear as subterms for the morphological type in the index of ICD-9-CM**. If both in situ and invasive cancer are present in the same lesion, assign behaviour code /3.

Examples of coding to the documented morphology

> **EXAMPLE 1**
> Pathology report states 'noninvasive squamous cell carcinoma of cervix'
> **Code** to 233.1 M8070/**2**
> (***Note***: ICD-9-CM description for M8070/2: *squamous cell carcinoma in situ NOS)*
>
> **EXAMPLE 2**
> Pathology report states 'noninfiltrating transitional cell carcinoma of bladder'
> **Code** to 233.7 M8120/**2**
> (***Note***: ICD-9-CM description for M8120/2: *Transitional cell carcinoma in situ)*

(Coding Matters, Volume 4, No. 1, July 1997)

Necrotising fasciitis – 728.86

This condition has been referred to as 'flesh-eating bacteria' by the media. It is a fulminating, bacterial infection that begins with severe or extensive cellulitis. This cellulitis spreads to the superficial and deep fascia. Thrombosis of the subcutaneous vessels and gangrene of the underlying tissues ultimately occur. The causal agent is commonly Group A Streptococcus. An additional code should be assigned to identify the responsible organism or any associated gangrene.

(Coding Matters, Volume 3, No. 1, July 1996)

Neonatal diagnoses – effective July 1996

The Neonatal Subcommittee of the Paediatrics CCCG met in late 1995 and discussed a number of issues relating to coding of neonates.

The subcommittee also considered which congenital abnormalities should be coded for neonates. Further work is continuing on developing a list of conditions which should not be coded for neonates. We'll keep you informed.
The coding standards set out below relate to specific interventions for the ill neonate. These standards will provide a valuable body of data over the next two years which will assist in improving AN-DRG classification of neonatal conditions.

Gastric gavage

Gastric gavage feeding (*96.35 Gastric gavage*) should be assigned **only when administered multiple (>1) times within an episode of care.**

Note: this code should not be used for gastric lavage procedures.

Hypoxic ischaemic encephalopathy (HIE)

This clinical syndrome is the encephalopathic process which follows a significant perinatal hypoxic-ischaemic injury. The encephalopathy is graded clinically as:

Grade 1 Hyperalertness, hyper-reflexia, dilated pupils, tachycardia but no seizures.
Grade 2 Lethargy, miosis, bradycardia, depressed reflexes (e.g. Moro), hypotonia and seizures.
Grade 3 Stupor, flaccidity, seizures, absent Moro and bulbar reflexes.

Coding
The ICD-9-CM index does not have an appropriate code assignment for HIE and leads to 767.0 Subdural and cerebral haemorrhage or 767.8 Other specified birth trauma, neither of which being appropriate for this syndrome. HIE should be coded as listed here.

The symptoms listed above should not be coded separately, except in the case of convulsions (Grade 3).

Grade 1 Code to *779.1 Other and unspecified cerebral irritability in newborn*
+
767.8 Other specified birth trauma

Grade 2 Code to *779.0 Convulsions in newborn*
+
767.8 Other specified birth trauma

Grade 3 Code to *779.2 Cerebral depression, coma ,and other abnormal cerebral signs*
+
779.0 Convulsions in newborn
+
767.8 Other specified birth trauma

Any co-existent severe birth asphyxia (768.5) should be coded if documented.

Maternal illness/incapacity to care

In cases where a neonate requires care due to maternal illness or 'incapacity to care', the appropriate code should only be assigned if the neonate is **exclusively dependent on nursing care for more than 24 hours (consecutive).**

Such cases would include 'baby for adoption' (*V68.89*) or maternal death (*761.6*).

Oxygen therapy (ACS 0016)

Code *93.96 Other oxygen enrichment* should be assigned only if the oxygen therapy (via cot, headbox, mask or cannula) was performed for more than four hours. Examples of diagnoses which may require oxygen therapy are 'transient tachypnoea' (770.6) or 'other respiratory problems after birth' (770.8).

Parenteral fluid therapy

Codes *99.15 Parenteral infusion of nutritional substance* and *99.18 Injection or infusion of electrolytes* should be assigned when used for management of carbohydrate, hydration or electrolyte disorders. Examples of diagnoses that may require parenteral fluid therapy are 'neonatal hypoglycaemia' (775.6) or 'other transient neonatal electrolyte disturbances' (775.5).

Note: these codes should **not be assigned** when these procedures are **part of resuscitation at birth**.

Parenteral antibiotics/anti-infectives

Codes *99.21 Injection of antibiotic* and *99.22 Injection of other anti-infective* should be assigned only when given for >24 hours. Examples of diagnoses which may require such treatment are 'perinatal infection' (771.8) or 'observation for suspected infectious condition' (V29.0).

Phototherapy (ACS 1601)

Code *99.83 Other phototherapy* should only be assigned when sustained phototherapy (**>12 hours**) is provided for the treatment of neonatal jaundice. Note that ACS 1601 requires that the diagnosis code for jaundice should only be assigned when phototherapy is given. Therefore, the jaundice diagnosis code should only be assigned when >12 hours of phototherapy is provided.

Transfusions (ACS 0016)

Codes *99.03 Other transfusion of whole blood*, *99.04 Transfusion of packed cells*, *99.07 Transfusion of other serum* (including plasma or albumin), *99.08 Transfusion of blood expander* (including dextran etc) should be coded when provided for the neonate. Examples of diagnoses which may require transfusion are 'foetal blood loss' (772.0), 'congenital anaemia' (776.5), 'polycythaemia neonatorum' (776.4), 'anaemia of prematurity' (776.6), 'shock' (785.5x), 'hypovolaemia' (276.5).

Note: these codes should **not be assigned** when these procedures are **part of resuscitation at birth**.

(Coding Matters, Volume 3, No. 1, July 1996)

Obstetrical procedures (ACS 1541)

Existing breech delivery codes have been renamed to facilitate easier coding:

72.51 Assisted breech delivery with forceps to aftercoming head

72.52 Other assisted breech delivery

72.53 Breech extraction with forceps to aftercoming head

72.54 Other breech extraction

The classical (74.0x) and lower segment (74.1x) caesarean codes have been expanded to indicate 'elective' and 'emergency'. Refer to ACS 1541 (Volume 4, page 133) for detailed definitions.

(Coding Matters, Volume 3, No. 1, July 1996)

Open wound with arterial and nerve damage

The overriding factor in a vascular injury is the potential of limb loss or compromise. In these instances where arterial and nerve damage may occur together, priority should be given to sequencing arterial damage first, followed by nerve damage, followed by laceration. Where there is no potential for loss of limb, yet both nerve and artery damage have occurred, the clinician should be consulted as to the correct sequencing.

(Coding Matters, Volume 2, No. 1, July 1995)

Phlebotomy

Phlebotomy is defined as incision of vein. However, it is clinically used to mean puncture of a vein in order to therapeutically remove blood from a patient with one of several different conditions (e.g., haemochromatosis, polycythaemia vera) or merely to withdraw blood for diagnostic testing. Venipuncture is a puncture of the vein and is a term synonymous with phlebotomy used to withdraw blood for diagnostic testing.

Effective July 1995, changes have been made to the index and the tabular of Volume 3 to clarify that phlebotomy is included under code 38.99 *Other puncture of vein*, and should be assigned to capture this procedure. Prior to this change phlebotomy was indexed to code 38.0x *Incision of vessel*, which included embolectomy and thrombectomy, which are significantly different procedures.

(Guidelines '95)

Place of occurrence for complication codes (ACS 2003)

The fifth digit '7' should be used only when the postoperative complication occurs during the episode of care during which surgery was performed.

The fifth digit '9' should be used only when the postoperative complication occurs after the patient is discharged from hospital after surgery.

Adverse effects of drugs:

The fifth digit '7' should be used only when the drug was prescribed in hospital and the patient was treated for the adverse effect during the same episode of care.

The fifth digit '9' should be used only when the drug is prescribed in hospital, the patient is discharged and then readmitted due to an adverse effect of the prescribed drug. Similarly, '9' should be used when a drug is prescribed by a GP and the patient is then admitted to hospital for treatment of the adverse effect.

Although there can be much discussion about the best way to do this, it should be borne in mind that although there is a requirement to use place of occurrence codes for all E codes (ACS 2003 PLACE OF OCCURRENCE), we recognise that place of occurrence is fairly meaningless and difficult to apply in cases of surgical complication and in certain instances of adverse effects of drugs. This standard should therefore serve to provide some national consistency in application.

(Coding Matters, Volume 2, No. 1, July 1995

Pleuroperitoneal shunt

Pleuroperitoneal shunting is considered an alternative palliative method in treating intractable pleural effusions, both benign and malignant, and also chylothorax. The shunt is a single-unit silicone rubber conduit consisting of a unidirectional valved pumping chamber located between fenestrated pleural and peritoneal catheters. Manual compression is required because pleural pressure is lower than peritoneal pressure. This procedure can be performed under local or general anaesthesia.

Effective July 1995, a new code, 34.05 *Creation of pleuroperitoneal shunt*, has been created. Use of this new code replaces previous advic to assign code 34.09 *Other incision of pleura*, for pleuroperitoneal shunting.

(Guidelines, '95)

Postoperative hypertension – 997.91

A common query in the past has been in relation to coding of postoperative hypertension which now has a new code, 997.91. A standard on how to interpret the term 'postoperative' is still in the development stage. It will be a valuable addition to coding standards as the decision to assign a condition to the 'complications' section is a vital one in terms of quality of data and quality of care indicators.

(Coding Matters, Volume 3, No. 1, July 1996)

Procedures (ACS 0016)

Multiple Procedures

The Australian Coding Standards (ACS) state:

"Procedures which may be related to the treatment of the principal diagnosis or secondary condition(s) or are required for research purposes, but are not surgical in nature, should be coded" (ACS 0016)

The definition of what is and is not 'surgical' is becoming more blurred wit the use of radiological intervention (e.g. fine needle aspiration), percutaneous procedures, cardiological interventional procedures (e.g. angioplasty), endoscopic therapeutic procedures and other treatments which may or may not be carried out in the operating theatre (e.g. mechanical ventilation).

Many of these traditional 'nonsurgical' procedures are very resource intensive and affect AN-DRG assignment. It is extremely important that they be coded, and if multiples of such procedures are performed, that multiple codes be assigned (e.g. multiple cardiac catheterisations, multiple endoscopy for treatment of oesophageal varices).

For the purposes of coding multiple procedures, apply the following general guidelines, noting the exceptions for existing *Australian Coding Standards* (ACS) which override these general guidelines:

Any procedure from Chapters 1-15 of Volume 3 ICD-9-CM which is performed more than once during an episode of care should be coded as many times as the procedure is performed.

*Exception*s:
- renal dialysis
- specific ACS standard which directs coders otherwise. For example: standard on multiple skin lesion excisions (ACS 0020 BILATERAL/MULTIPLE PROCEDURES).

Any procedure from Chapter 16 of Volume 3 ICD-9-CM need only be coded once

Inclusions:
- blood transfusions*
- CT scans
- ECT

Exceptions:
- procedures which may affect AN-DRG assignment**
- specific ACS standard which directs coders otherwise
- multiple dressings to ulcers, burns or wounds

*Note: paragraph c) no longer applies in light of the above standard

**Note: procedures which may affect AN-DRG assignment are indicated by an asterisk in Volume 3 of the *Australian Version of ICD-9-CM*.

(Coding Matters, Volume 2, No. 1, July 1995)

Procedures which can be used with 650 (ACS 1505)

Any or all of the following procedure codes can be assigned on a record with a principal diagnosis of 650:

03.91 Injection of anaesthetic into spinal canal for analgesia

66.29 Other bilateral endoscopic destruction or occlusion of fallopian tubes

73.09 Other artificial rupture of membranes

73.59 Other manually assisted delivery

73.6 Episiotomy

75.32 Foetal EKG (scalp)

75.34 Foetal monitoring, NOS

(Coding Matters, Volume 1, No. 2, October 1994)

Procedures which can be used with 650 (ACS 1505)

Add this following procedure to the list of procedures which can be used with 650:

66.39 Other bilateral destruction or occlusion of fallopian tubes

(Coding Matters, Volume 1, No. 3, January 1995)

Prophylactic organ removal (Aust)

Some patients are now electing to undergo prophylactic organ removal (e.g., mastectomy and oophorectomy) to prevent the occurrence of cancer. This is being seen most often in women who have a family history of breast or ovarian cancer. To identify these women, and to correspond to a similar code in ICD-10, new codes have been created for encounter for prophylacticorgan removal (code V50.41 *Breast*; code V50.42 *Ovary*; and code V50.49 *Other*).

The code is intended for use in patients who undergo removal of a nondiseased organ in an effort to prevent disease, generally a malignancy. It should not be used for the removal of organs for the treatment of cancer (e.g. removal of ovaries for treatment of breast cancer or removal of testes for treatment of prostate cancer). Removal of the testes or ovaries for treatment of another malignancy is a therapeutic, not a prophylactic measure and the principal diagnosis is the malignant condition. This advice applies even if the malignancy had been previously excised, and the patient is admitted for therapeutic removal of an organ.

Note: where a distinct clinical diagnosis is made which accounts for the patient s elective organ removal, then such a condition (e.g. chronic pain, chronic infection, carcinoma of other breast or family history or malignant neoplasm of breast) should be coded as the principal diagnosis, rather than the V50.4x (which can be sequenced as a secondary condition code).

(Guidelines '95)

Pruritic urticarial plaques of pregnancy (PUPP)

This is a distinct, not uncommon condition involving intensely pruritic, erythematous, urticaria-like papules and plaques, arising in the third trimester. The eruption usually resolves promptly after delivery and does not usually recur in subsequent pregnancies.

Code to: *646.8* *Other specified complication of pregnancy*, and
698.8 *Other specified pruritic conditions*

(Coding Matters, Volume 2, No. 4, April 1996)

Schizophrenia – 295 (ACS 0501)

For codes 295.4, 295.5 and 295.6, only a fifth digit of '0' should be applied, as the other fifth digits are clinically meaningless with these conditions.

(Coding Matters, Volume 3, No. 1, July 1996)

Screening/behavioural risk factor

Historically, screening codes have been used for population screening only, not for individuals. However, these codes may be used to identify patients receiving routine screening during a health care encounter. Effective July 1995 instructional notes have been added to clarify the use of the screening codes V73-V82.

A new category, V69, *Problems related to lifestyle*, has been created; new codes in this category have codes that identify risk factors such as lack of physical exercise (code V69.0 *Lack of physical exercise*), inappropriate diet and eating habits, (code V69.1 *Inappropriate diet and eating habits*)and high-risk sexual behaviour (code V69.2 *High-risk sexual behaviour*), and gambling and betting (code V69.3 *Gambling and betting*).

Codes from this new category are to be assigned as an additional diagnosis(es) when the physician has documented the presence of a risk factor(s) in the health record. These factors are considered clinically important in designing surveillance and prevention programs. The codes may be used as a principal diagnosis and may also be used in the inpatient and outpatient settings. Codes should not be used as a principal diagnosis when the patient is being counselled to modify the risk behaviour. In these cases, the principal diagnosis should be code V65.3 *Dietary surveillance and counselling*, or code V65.4 *Other counselling NEC*, with additional codes from category V69 to identify other risk factors present.

(Guidelines '95)

Secondary hypertension – 405 (ACS 0928)

New codes have been created to distinguish hypertension caused by renal disorders (such as glomerulonephritis, polycystic kidney disease or nephropathy), and hypertension caused by renal artery disorders (usually renal artery stenosis). The new code structure is:

405	Secondary hypertension		
	405.0	Malignant	
		405.01	Renovascular
New		405.02	Due to renal disorders
		405.09	Other
	405.1	Benign	
		405.11	Renovascular
New		405.12	Due to renal disorders
		405.19	Other
	405.9	Unspecified	
		405.91	Renovascular
New		405.92	Due to renal disorders
		405.99	Other

The specific condition causing the hypertension should be coded and sequenced after the appropriate 405.xx code.

(Coding Matters, Volume 3, No. 1, July 1996)

Second look laparotomy

This new code (54.13) would be used in cases of malignancy where a second laparotomy is required after the initial surgery to stage the malignancy.

(Coding Matters, Volume 3, No. 1, July 1996)

Stemetil poisoning

The NCCH has had some queries about why Stemetil, a drug often used for antiemetic purposes, is listed in the Drug Table with diagnosis code *969.1 Phenothiazine-based tranquillisers* rather than code *963.0 Antiallergic and antiemetic drugs*.

The reason for this classification is that both ICD-9-CM and ICD-10 usually classify drugs according to the **type** of drug (phenothiazine) rather than the way it effects the body (antiemetic). This is a consistent way of classifying drugs, as many drugs have more than one 'action' on the body.

It should be noted that under 963.0 there is an exclusion note alerting coders to the fact that 'Phenothiazine-based tranquillisers' are coded to 969.1. Stemetil is the brand name for prochlorperazine maleate, a phenothiazine.

(Coding Matters, Volume 3, No. 3, January 1997)

Streptococcus pneumonia (ACS 0103)

ACS 0103 STREPTOCOCCAL INFECTION includes *S. pneumoniae* (pneumonococcus) under the group 'other' (ACS page 28). These terms are synonymous, (as are pneumonococcus and pneumococcus) so coders should take care not to use the ICD-9-CM Index entry 'Infection, pneumococcus NEC' as this will lead to 041.2, rather than the correct code 041.09 *Other streptococcus*.

(Coding Matters, Volume 2, No. 1, July 1995)

Stroke (ACS 0605) – effective 1 July 1996

Late effect
The usual application of a late effect is where a deficit arises as a result of a condition and often occurs later than the initial condition, e.g. scoliosis following rickets. Stroke differs, in that the deficits are an immediate result of the stroke. For this reason, the following standard should be applied.

Example 1

A patient suffers a stroke on 1/1/96 and is transferred to a rehabilitation facility on 7/1/96 for continuing rehabilitation.

The first episode (1/1 - 7/1) is assigned code 436 plus codes for any deficits.

Patient transferred for rehabilitation following a previous admission for stroke. The patient suffers from hemiparesis and aphasia.

Second episode: Code V57.xx (rehabilitation), 436 (stroke), 342.9 (hemiparesis) and 784.3 (aphasia).

While the patient is receiving continuing treatment, regardless of the period of time elapsed since the stroke, assign code 436 with any applicable deficit codes (e.g. hemiplegia).

should only be used when the treatment period is complete but residual deficits are still manifest. For example:

Example 2

Patient admitted for excision of multiple BCCs. Examination revealed residual hemiparesis from a previous stroke. No treatment of the residual hemiparesis occurs during the episode of care.

Assign codes for principal diagnosis for BCC, hemiparesis and 438 (indicating that neither the stroke nor the hemiparesis is receiving treatment).

a) Severity
The Neurosciences Clinical Coding and Classification Group (CCCG) has produced a list of additional diagnosis codes which give some indication as to the severity of a stroke episode. For coders, it is interesting to note that it is not necessarily the deficits, such as hemiplegia, which indicate that a stroke is ‘severe’. This table is provided on the next page (p6) primarily for interest, as the conditions listed here would be coded routinely during the abstraction process. However, note that for a stroke case, dysphagia, urinary incontinence and faecal incontinence, should only be coded when certain criteria are met.

STROKE - COMPLICATING ADDITIONAL DIAGNOSES	
ADDITIONAL DIAGNOSIS	**ICD-9-AM CODE/S**
Urinary tract infection, site not specified	599.0
Pneumonitis	507.0
Pneumonia	480.0, 480.1, 480.2, 480.8, 480.9, 481, 482.0, 482.1, 482.2, 482.30, 482.31, 482.32, 482.39, 482.4, 482.81, 482.82, 482.83, 482.89, 482.9, 483.0, 483.8, 484.1, 484.3, 484.5, 484.6, 484.7, 484.8, 485, 486
Decubitus and lower limb ulcer	707.0, 707.1
Embolism and venous thrombosis	415.11, 415.19, 453.8
Dysphagia - only to be coded when requiring nasogastric tube/ enteral feeding	787.2
Urinary incontinence - only to be coded when still present 7 days after admission date.	788.30, 788.31, 788.32, 788.33, 788.34, 788.35, 788.36, 788.37, 788.39
Faecal incontinence - only to be coded when still present 7 days after admission date.	787.6
Urinary retention	788.20, 788.21, 788.29
Aphasia	784.3
Septicaemia	038.0, 038.1, 038.2, 038.3, 038.40, 038.41, 038.42, 038.43, 038.44, 038.49, 038.8, 038.9
Other bacterial diseases (e.g. gangrene)	040.0, 040.1, 040.2, 040.3, 040.81, 040.89, 041.00, 041.01, 041.02, 041.03, 041.04, 041.05, 041.09, 041.10, 041.11, 041.19, 041.2, 041.3, 041.4, 041.5, 041.6, 041.7, 041.81, 041.82, 041.83, 041.84, 041.85, 041.89, 041.9, 785.4

(Coding Matters, Volume 3, No. 1, July 1996)

Stroke (ACS 0605)

Code 436, *Acute, but ill-defined, cerebrovascular disease* is a non-specific code, and should only be used when no better diagnosis is available [e.g. *Cerebral embolism with infarction* (434.11) or *Subdural haemorrhage* (432.1)]. Clinical coders are encouraged to seek more specificity from clinicians if documentation is poor and if radiology and other reports are not present.

(Coding Matters, Volume 3, No.3, January 1997)

Suprapubic catheterisation

Coders should note the difference between codes *57.17 Percutaneous cystostomy* and *57.18 Other suprapubic cystostomy*. 57.17 should be assigned for closed (percutaneous) suprapubic catheterisation which is often performed after hysterectomy. 57.18 is an open operation and would involve a urologist and would therefore be used less often.

(Coding Tips, Volume 2, No. 3, January 1996)

Suprapubic catheterisation

To further clarify the use of codes *57.17 Percutaneous cystostomy* and *57.18 Other suprapubic cystostomy* discussed previously in *Coding Matters*, Volume 2, No 3, the following advice is provided by Mr Douglas Travis (Nephrology/Urology Clinical Coding and Classification Group [CCCG]):

> A percutaneous cystotomy (57.17) is a simple procedure that is performed either under local anaesthetic or at the end of an operative procedure where a needle of some form is introduced through the skin into the bladder. There are different variations depending upon the actual hardware used as to what happens next, but essentially a tube is placed down the track created by the needle into the bladder. The tube is on occasions sutured to the skin and that is the end of the procedure.
>
> A suprapubic cystotomy (57.18) involves a formal operation through an incision in the lower abdomen. The bladder is formally exposed and surgically opened. The opened area of the bladder is then sutured to the skin creating a stoma. On occasions a formal stoma is not made rather the bladder once exposed has a tube placed in it via a stab incision and that is brought out through the wound.

Coding
Assign *57.17 Percutaneous cystostomy* for operative descriptions such as 'SPC' (suprapubic catheterisation) or 'stab cystotomy' which usually follow an operative procedure. Although the term 'stab' may be used in relation to an open cystotomy (57.18) a procedure description of 'stab cystotomy' should be interpreted as a percutaneous cystotomy (57.17). The terms 'cystostomy' and 'cystotomy' are used synonymously in this context.

(Coding Matters, Volume 3, No. 2, October 1996)

Sympathectomy

Thanks to the Australian Pain Society for this insight into sympathectomy and its correct classification.

Category *05.2 Sympathectomy* relates to **surgical sympathectomy** and is a formal operative procedure carried out under general anaesthesia involving exploration of the lumbar sympathetic chain extraperitoneally with division and resection of the lumbar sympathetic nerves.

A lumbar **chemical sympathectomy**, code *05.32 Injection of neurolytic agent into sympathetic nerve*, is performed with the patient awake or under mild sedation and local anaesthesia. Using an image intensifier a needle is placed percutaneously in the region of the lumbar sympathetic chain. The current neurolytic agent is 10% phenol which has essentially the same effect as the open surgical sympathectomy.

Coders' note
No index entry exists for 'Sympathectomy, chemical' so this should be noted in your index and tabular list.

(Coding Matters, Volume 3, No. 2, October 1996)

Tobacco, use of (ACS 0503)

Australian Coding Standard 0503 (Volume 4, page 63) states that the codes for use of tobacco 'should be assigned as additional diagnoses for all cases where documentation is provided regarding tobacco consumption'. Use of tobacco may fall into one of the following codes:

V15.82 History of tobacco use

V15.83 Current use of tobacco

305.1 Tobacco use disorder

Please consult this Standard for definitions of each term. These codes were introduced for use in 1995 as clinicians have realised that smoking may be linked to a number of diseases, and will undoubtedly use these codes for medical research in years to come.

(Coding Matters, Volume 3, No. 4, April 1997)

Toxic effect of second–hand smoke

A new E-code, E869.4 *Second-hand tobacco smoke*, has been created. This code should be used to identify nonsmokers who have been exposed to "second-hand" smoke. The assignment of this code is dependent upon the clinicians documentation. The code should not be assigned as a principal diagnosis but may be assigned when the clinician has stated that second-hand smoke or environmental tobacco smoke is the external cause of the patient s condition. The code may not be assigned in the absence of a condition or symptom.

Also, note that the fifth digits for category 305 *Nondependent drug use disorder*, no longer apply to subcategory 305.1 *Tobacco use disorder*. Patients with a history of tobacco use, but no longer smokers, would have code V15.82 *History of tobacco use*, assigned. A diagnostic statement of "in remission" should now have code V15.82 assigned even if the patient is no longer a smoker, regardless of the length of time the patient has not smoked. Code 305.1 should be assigned if the clinician has documented that the patient is still smoking or under treatment for tobacco use.

(Guidelines '95)

Transjugular intrahepatic portosystemic shunt

The transjugular intrahepatic portosystemic shunt (TIPS) is a device designed to achieve portal decompression in patients with variceal haemorrhage secondary to portal hypertension. The shunt is created using a transjugular approach between a portal and hepatic vein. An index entry has been added to Volume 3 to directly reference TIPS to code 39.1 *Intra-abdominal venous shunt*.

(Guidelines '95)

Transvascular percutaneous cardiac intervention

35.74 Percutaneous closure of cardiac septal defect
35.85 Percutaneous closure of cardiac collateral vessels
35.86 Balloon dilation of coarctation of the aorta
35.87 Percutaneous closure of patent ductus arteriosus
36.06 Percutaneous intracoronary stent implant
39.90 Dilation/stenting of major great vessels

Percutaneous closure of cardiac septal defect (35.74)
This procedure will most often be performed in patients with congenital heart disease such as atrial or ventricular septal defect in children, but has been reported in some adults who have suffered post myocardial infarction ventricular septal defect. It involves the introduction of a device via combined transvenous, and often transarterial, route. This may be from the femoral or jugular veins, and the femoral artery when necessary. The device is a double disk or clam shell shaped prosthesis which is folded in a specialised delivery system. The prosthesis is delivered to the heart under image intensification control, often with the assistance of ultrasound. The occluding prosthesis is left *in situ* at the end of the procedure. This is a relatively specialised procedure that will probably be limited to a few selected major entres.

Percutaneous closure of cardiac collateral vessels (35.85)
This would generally be performed in children and young adults with congenital heart disease, and would usually relate to naturally occurring pulmonary collateral vessels. These are small arteries arising from the aorta and generally connecting with the pulmonary arteries distal to the main branches. A variety of "prostheses" such as small coils, detachable balloons, or microaggregates are generally delivered via percutaneous femoral arterial approach directly into the collateral in the hope of creating obstruction and closure of the vessel. This technique may occasionally be used to close surgically created collateral vessels such as systemic to pulmonary artery shunts.

Balloon dilation of coarctation of the aorta (35.86)
This procedure is predominantly performed in infants and children, and in most cases in patients who have had previous repair of coarctation of the aorta. In most cases a balloon catheter is introduced via a femoral artery and inflated over the narrowed area of the aortic lumen to increase the size of the lumen. The catheter is then removed. This may not prove a permanent solution, but in many cases surgical intervention can be avoided.

Percutaneous closure of patent ductus arteriosus (35.87)
This is a procedure mostly performed in children with PDA, although it has been used in Australia and overseas for selected adults. It avoids the need for surgical thoracotomy and involves the insertion of a prosthesis (a variety of forms are available) into the patent ductus arteriosus to occlude

the communication. Mostly the prosthesis is delivered in a folded form from the femoral vein, but it may occasionally be introduced from the femoral artery approach. The occluding prosthesis is left *in situ* at the end of the procedure. This is a relatively specialised procedure that will probably be limited to a few selected major centres.

Percutaneous intracoronary stent implant (36.06)
This is a procedure performed in adult patients with obstructive coronary artery disease. In general, these patients will have suffered chest pain (angina) or previous myocardial infarction. The stent is a small expandable tubular device delivered with a specialised balloon catheter, usually from the femoral arterial route, and expanded inside the coronary artery to open out the lumen. The stent is left in position after the procedure.

Dilation/stenting of major great vessels (not collateral) (39.90)
Major vessels would include the thoracic aorta, pulmonary arteries, pulmonary veins, and possibly the superior or inferior vena cavae or intracardiac baffles. Most patients will be children or young adults who have undergone surgery for congenital heart disease and in whom residual narrowings have not been relieved surgically or have become evident after operation. The objective would be to open out an area of narrowing in these vessels, in a similar fashion to balloon dilation of coarctation of the aorta. A balloon catheter alone may be used, and may be introduced from the femoral vein or artery, or jugular or subclavian vein, depending on the site of obstruction. Where dilation of the narrowed area with the balloon alone is not successful, a stent (an implantable and expandable tubular prosthesis) may be delivered with the balloon catheter and left *in situ* to try and maintain the increased lumen size of the vessel.

(Guidelines '94)

Ulcerative oesophagitis – 530.11 (ACS 1121)

A new code was considered for this condition which is often a source of queries from coders. However, there are considerable difficulties surrounding the terms used to describe oesophagitis which precluded creation of a new code. For example, doctors use the 'generic' term reflux oesophagitis to describe cases where ulceration is present but also when ulceration is not present. As most oesophagitis is caused by reflux of peptic juices and acid, it was decided that 530.11 Reflux oesophagitis was the best solution. As mentioned in ACS 1121, the code for ulceration of oesophagus, 530.2 should not be assigned for ulcerative oesophagitis.

(Coding Matters, Volume 3, No. 1, July 1996)

Unwanted pregnancy (ACS 1511)

V61.7 *Other unwanted pregnancy* should be assigned rarely. Specifically, it should not be used as the principal diagnosis in admissions for termination of pregnancy. Admission for termination of pregnancy should be assigned a principal diagnosis code of 635.xx *Legally induced abortion.*

(Coding Matters, Volume 2, No. 3, January 1996)

Vesicoureteral reflux

Vesicoureteral reflux is the reflux of urine from the bladder into the ureter. This condition may damage the upper urinary tract and result in bacterial infections and in extreme cases, kidneyfailure. This code has been expanded to identify the presence of reflux nephropathy. Instructional notes have also been added to direct coders to assign all codes associated with reflux. For example:

593.7 Vesicoureteral reflux
Use additional code to identify:
chronic pyelonephritis (590.00-590.01)
renal agenesis (753.0)
renal dysplasia (753.15)
593.70 Unspecified or without reflux nephropathy
593.71 With reflux nephropathy, unilateral
593.72 With reflux nephropathy, bilateral
593.73 With reflux nephropathy NOS

(Guidelines '95)

Vibrio vulnificus – 005.81

This bacteria can be isolated from seawater, zooplankton and shellfish from the Gulf of Mexico and along both coasts of the United States of America. It can manifest as a septicaemia after ingestion of raw shellfish, particularly oysters or as a wound infection (progressing to cellulitis, fasciitis, or myostitis) after exposure to seawater or after cleaning shellfish.

(Coding Matters, Volume 3, No. 1, July 1996)

Vitiligo

Vitiligo is the absence of melanocytes in the skin causing hypopigmentation. These patients are particularly susceptible to sunburn and skin cancers. Prior to July 1995, this condition was grouped with all forms of dyschromia. This category has been expanded to allow for a unique code for vitiligo (code 709.00 *Dyschromia, unspecified*, code 709.01 *Vitiligo*, and code 709.09 *Other dyschromia*).

(Guidelines '95)